Appendix 1 - Model # 2D

ENCLOSURE IV

UNIVERSE REQUEST FOR SAMPLES TO BE REVIEWED BY CMS

Please provide the CMS Regional Office (RO) with a universe listing for each sample described in Part I of this document, in the electronic format described below, no later than [date (seven weeks prior to the review for reviews conducted in the office/four weeks prior to the review for reviews conducted onsite)]. If you would like to have an electronic copy of the universe template, please go to www.cms.hhs.gov/healthplans/monitoring/2003guide.asp and click on "Model Letters." The universe listing is the complete list of all Medicare beneficiary transactions that took place during the review period, from which CMS will randomly choose "cases" to review for compliance. All of the samples CMS will review are for Medicare members of the M+CO. Each universe described will indicate any delegated entities for which (name of M+CO) must provide additional universes. Unless otherwise specified, the review period is (enter start and end dates of review period).

If you are unable to produce any of the universes requested in Part I, please contact (name) immediately.

Prior to the review, the RO will notify you of the specific cases we will review for each sample listed under Part I and Part II. Also, we will notify you of the materials necessary to document each case.

Data Transmission Vehicle

(Name of M+CO) must submit the universe listings on one readable CD. If this is impossible or if you have any questions, please contact (name).

File Format

The universe listings must be submitted either as

- Microsoft Excel files (Version 1997)
- Comma delimited **.csv** files

Number of Files

For each worksheet (e.g. **ws-dn1, ws-rc1** etc). the M+CO should submit either

- 1 file containing the whole universe (*the M+CO chooses this option if the file contains at most 65,530 records*)
- 6 files each containing one month of data (*the M+CO chooses this option if each month of data contains at most 65,530 records*)
- 24-26 files each containing one week of data (*the M+CO chooses this option if each week of data contains at most 65,530 records*).

In the event that some week contains more than 65,530 records please call the RO to discuss alternative arrangements.

It is important that no other options be used. For example, it would be unacceptable to submit two files each with 3 months of data. Similarly it would be unacceptable to give 5 files with 5 months of data and 4 files with the remaining 4 weeks. Only the 3 options above are acceptable for submission.

Names of Files

All of the files should be named with the three letter code of the worksheet to which the universe corresponds. Files that contain data for the entire review period should be named with the three letter code of the worksheet to which the universe corresponds. Files that contain data for each month should begin with a "m," followed by the number of the month that the data captures, followed by a hyphen "-" and then the three letter code of the worksheet to which the universe corresponds. Files that contain data for each week should begin with a "w," followed by the number of the week that the data captures, followed by a hyphen "-" and then the three letter code of the worksheet to which the universe corresponds.

For example:

- Suppose the universe for **ws-rc2** consists of one file (with all 6 months of data). Then that file must be named **rc2.xls** or **rc2.csv**

- If the universe for **ws-rc2** consists of 6 files (one for each month) then the files must be named **m1-rc2.xls, m2-rc2.xls**….**m6-rc2.xls** (or **csv** files). Name formats must be strictly adhered to. For example: It is unacceptable to name the files by the month names (**jan-rc2.xls**) or to use an underscore vs a hyphen (**m1_rc2.xls**)

- If the universe for **ws-rc2** consists of 24-26 files (one for each week) then the files must be named **w1-rc2.xls, w2-rc2.xls, w3-rc2.xls,** etc.

It is very important that all names adhere exactly to the above format. Here is an real world example: A particular M+CO may have only 300 grievances but 300,000 provider claims. Then

- It would submit one file for grievances: **gv1.xls** or **gv1.csv**
- It would submit 6 files for claims (each under 65,530) named: **m1-oc1.xls, m2-oc1.xls…**

Folders and Workbooks

Do not put any files in folders. Do not put any files in workbooks. Save the files directly to the CD.

Name of CD-ROM

The CD-ROM for the M+CO universes must be named H####-MCO, where H#### is the M+CO's contract number. Make sure there is a hyphen between the contract number and MCO (use MCO, not the M+CO's name).

Delegated Entities

If you are submitting any files for delegated entities, you must submit the universe listings for each delegated entity on one CD per delegated entity (e.g., if there are four delegated entities,

you must submit only four CDs). You must use the same naming convention for the universes as described above. Do not add anything to the file name, such as the name of the delegated entity.

Name of CD-ROM for Delegated Entities

The CD-ROM for each delegated entity must be named H####-(name of delegated entity-not to exceed 15 letters), where H#### is the M+CO's contract number. Make sure there is a hyphen between the contract number and the delegated entity's name. The name of the delegated entity must not contain any spaces, underlines or periods. It may contain hyphens and upper and lower case letters. For example, if a delegated entity is See Well Vision Group, the name could be H####-See-Well-Vision.

Worksheet Field Names

Use the format described below. In particular:

- Do NOT place the word "worksheet" and the "worksheet name" (e.g., ER2) in the file. The worksheet name shown in the boxes below is there for your reference only.
- The first row should contain the number of the worksheet columns to which the data corresponds (as provided below in the Worksheet Field Names boxes). Do NOT place the words "1st row in submitted file should read:" in the file.
- The 2nd row should contain the names of the worksheet columns to which the data corresponds (as provided below in the Worksheet Field Names boxes). Do NOT place the words "2nd row in submitted file should read:" in the file.
- The 3rd row should contain data entered by the M+CO
- The file should be flat format—only rows and columns
- There should be no comments, subtotals or blank rows anywhere in the data.

Whether you submit csv files or Excel files, please adhere to the format shown below. Each file must contain 2 header rows followed by the data.

Field formats

- Dates: Must be in excel **mm/dd/yyyy** or **m/d/yy** or **m/d/yyyy** format. Traditional mainframe formats (**yyyymmdd**) are not acceptable.

- Names: Please use ***FIRST NAME SPACE LAST NAME*** format. Please do not use commas with the names (as this will interfere with the csv feature of some files).

- HIC #: Please record leading zeroes, if any.

Worksheet Field Names

Worksheet	ER2		
1st row in submitted file should read:	1	2	7
2nd row in submitted file should read:	Member Name	HIC #	Date Denial Notice Sent

Worksheet	DN3		
1st row in submitted file should read:	1	2	4
2nd row in submitted file should read:	Member Name	HIC #	Disenrollment Date

Worksheet	DN4		
1st row in submitted file should read:	1	2	4
2nd row in submitted file should read:	Member Name	HIC #	Disenrollment Date

Worksheet	MR1
1st row in submitted file should read:	1
2nd row in submitted file should read:	Marketing Representative's Name

Worksheet	OC1	
1st row in submitted file should read:	1	3
2nd row in submitted file should read:	Claim Number	Date Claim Paid

Worksheet	OC2	
1st row in submitted file should read:	1	3
2nd row in submitted file should read:	Claim Number	Date Claim Denied

Please provide only (Member Name or HIC #, RO reviewer decision) **in column 1 for the worksheets listed below this statement (WSs OP1-GV1). Also, please provide only the date (and not the time) the request was received for worksheets OP2 and RP3 under heading "Date & Time Expedited Request Received," column 4.**

Worksheet	OP1	
1st row in submitted file should read:	1	9
2nd row in submitted file should read:	Member Name or HIC #	Date Denied

Worksheet	OP2	
1st row in submitted file should read:	1	4
2nd row in submitted file should read:	Member Name or HIC #	Date & Time Expedited Request Received

Worksheet	OP3	
1st row in submitted file should read:	1	8
2nd row in submitted file should read:	Member Name or HIC #	Date Approved

Worksheet	RC1	
1st row in submitted file should read:	1	7
2nd row in submitted file should read:	Member Name or HIC #	Date Member Notified

Worksheet	RC2	
1st row in submitted file should read:	1	4
2nd row in submitted file should read:	Member Name or HIC #	Date Recon Request Received

Worksheet	RP1	
1st row in submitted file should read:	1	9
2nd row in submitted file should read:	Member Name or HIC #	Date Member Notified

Worksheet	RP2	
1st row in submitted file should read:	1	4
2nd row in submitted file should read:	Member Name or HIC #	Date Recon Request Received

Worksheet	RP3	
1st row in submitted file should read:	1	4
2nd row in submitted file should read:	Member Name or HIC #	Date & Time Expedited Recon Request Received

Worksheet	GV1	
1st row in submitted file should read:	1	4
2nd row in submitted file should read:	Member Name or HIC #	Date Grievance Received

Part I

Samples to be Selected from M+CO Data
(M+CO must provide these universes to the RO.)
Any variances to the review period and any delegated entities for which universes are required are specified under the applicable universe description(s) below.

M+CO Denial of Enrollment **Worksheet WS-ER2**

Purpose: To determine if the M+CO processes enrollment denials per CMS standards.

Universe: All cases that the M+CO denied, during the review period, without having submitted the accretion information to CMS. These denials might be for reasons such as not residing in the service area, failing to complete the application within specified timeframes, the presence of ESRD (and no exception), the enrollee's lack of Part A or B of Medicare, and/or denials because the M+CO is closed or has a capacity limit in effect. Cancellations of enrollment are not denials and must not be included in the universe.

Optional - Delegated Entities: Same universe as above for (names of delegated entities).

Optional - Review Period Variance:

NOTE TO REVIEWERS: The above two items ("Delegated Entities" and "Review Period Variance") will not appear on this template under other universes but the reviewer should add them as required under applicable universes.

Involuntary Disenrollment Due to Nonpayment of Premiums Worksheet WS-DN3

NOTE TO REVIEWERS: This universe should not be requested if the M+CO does not charge plan premiums OR if the M+CO's policy is not to disenroll any members for nonpayment of premiums.

Purpose: To determine if involuntary disenrollments for nonpayment of monthly premiums were processed per CMS standards.

Universe: All involuntary disenrollments for nonpayment of plan premiums that became effective during the review period.

Involuntary Disenrollment Due to Permanent Move **Worksheet WS-DN4**

Purpose: To determine if involuntary disenrollments for a permanent move out of the service area were processed per CMS standards.

Universe: All involuntary disenrollments for permanent moves outside the plan service area that became effective during the review period.

Review of Marketing Representative Information **Worksheet WS-MR1**

NOTE TO REVIEWERS: This is an optional worksheet. This universe should not be requested if there is no need to review the information.

Purpose: To determine if the M+CO Marketing Representatives meet CMS standards.

Universe: The complete roster of Marketing Representatives who were employed by the M+CO and sold M+CO products during the review period. "Account Executives," who might only service/sell to a single large employer group that enrolls Medicare beneficiaries should be included in the universe.

Provider Credentialing **Worksheet WS-PR1**

NOTE TO REVIEWERS: If the M+CO is deemed, this universe should not be requested.

Purpose: To determine compliance with regulatory requirements for the selection and evaluation of providers in accordance with 42 CFR 422.204(b).

Universe: The Health Services Delivery table, HSD-2, Provider list that lists physicians and other practitioners by county. This table delinates if the credentialing function is delegated or not.

Provider Contracts **Worksheet WS-CN1**

NOTE TO REVIEWERS: If the M+CO is deemed, HSD tables will not be submitted. Therefore, request the latest provider directories for the universe if the M+CO is deemed.

Purpose: To determine whether the M+CO's first tier and downstream contracts or written arrangements with providers (including facilities), contain CMS-required elements.

Universe: Sentence to be used when M+CO is not deemed: The delegated entity group listing previously provided to the RO by the M+CO, all of HSD Table 2, and the hospitals and SNFs on HSD Table 3. Sentence to be used when M+CO is deemed: The delegated entity group listing previously provided to the RO by the M+CO and the latest provider directories.

Non-Contracted Provider Paid Claims **Worksheet WS-OC1**

Purpose: To determine if the M+CO: (1) pays for: referral services to non-contracted providers, which were made by the M+CO or its contracted providers; and emergency, post stabilization, temporarily out of area renal dialysis, and urgently needed care, without prior authorization; (2) pays clean claims from non-contracted providers within 30 days of receipt; (3) makes accurate decisions regarding what constitutes a clean claim; and (4) pays interest on clean claims not paid within 30 days of receipt. (A provider is determined to be a "contracting provider" if he/she has entered into a written agreement with the M+C organization that includes the provision that prohibits providers from holding an enrollee liable for payment of any fees that are the obligation of the M+C organization [422.502 (i)(3)(i)]. Conversely, a provider is determined to be a "non-contracting provider" if he/she has not entered into such a written agreement.

Universe: All non-contracted provider paid claims paid during the review period. A claim consists of one or more services/line items with a unique bill date and a unique paid date. If at least one paid line item in the claim is greater than $0.00 (and no items are denied), the claim belongs in this universe. There should be only one record in the universe for each entire claim (line items should be rolled up).

Denied Claims **Worksheet WS-OC2**

Purpose: To determine if the M+CO: (1) complies with the regulatory requirements to provide notice of an adverse organization determination; (2) processes claims within 60 days of receipt; and (3) inappropriately denies services (e.g., Medicare-covered services, emergency and urgently needed care, and benefits covered in the M+CO's Evidence of Coverage). (A provider is determined to be a "contracting provider" if he/she has entered into a written agreement with the M+C organization that includes the provision that prohibits providers from holding an enrollee liable for payment of any fees that are the obligation of the M+C organization [422.502 (i)(3)(i)]. Conversely, a provider is determined to be a "non-contracting provider" if he/she has not entered into such a written agreement.

Universe: All claims denied during the review period which are: (1) non-contracted provider claims denied for the following reasons: non-emergent, non-urgent out of area care, not a covered service, and unauthorized services (exclude claims that were denied because they are duplicate claims) and (2) contracted provider denied claims **that resulted in member liability** during the review period (exclude claims that were denied because they are duplicate claims). A claim consists of one or more services/line items with a unique bill date and a unique denied date. If one line item in the claim is denied, the claim belongs in this universe. There should be only one record in the universe for each entire claim (line items should be rolled up).

Standard Pre-Service Denials **Worksheet WS-OP1**

Purpose: To determine whether the M+CO complies with regulatory requirements for timeliness and member notice when initially denying member requests for service. Also, to determine whether cases categorized by the M+CO as organization determinations are in fact organization determinations rather than reconsiderations.

Universe: Standard pre-service organization determinations made during the review period that were not fully favorable to the member. This includes any notices of discontinuation of services that were issued. Retrospective denials, i.e., denials made after the service has been rendered, must not be included in the universe.

Requests for Expedited Organization Determinations **Worksheet WS-OP2**

Purpose: To determine if the M+CO complies with regulatory requirements for timeliness and member notice when processing member requests for expedited organization determinations. Also, to determine if cases categorized as requests for expedited organization determinations are, in fact, requests for organization determinations rather than requests for reconsideration or expedited reconsideration.

Universe: All requests for expedited organization determinations received during the review period, regardless of whether they were expedited or not.

Favorable Standard Pre-Service Organization Determinations Worksheet WS-OP3

NOTE TO REVIEWERS: This is an optional worksheet. This universe should not be requested if there is no need to review the information.

Purpose: To determine if the M+CO and/or delegated entity complies with regulatory requirements for timeliness when initially approving enrollee requests for service. Also, to determine if cases categorized as organization determinations are, in fact, organization determinations rather than reconsiderations.

Universe: Standard pre-service organization determinations of requests for services made during the review period and submitted by a member (not a physician) that were fully favorable to the member. Retrospective approvals, i.e., approvals made after the service has been rendered, must not be included in the universe.

Favorable Claims Reconsiderations **Worksheet WS-RC1**

Purpose: To determine whether the M+CO complies with regulatory requirements for timeliness and member notice when approving member requests for claims payment on reconsideration.

Universe: All claim reconsiderations determinations made during the review period that resulted in the M+CO reversing its initial denial.

Unfavorable Claims Reconsiderations **Worksheet WS-RC2**

NOTE TO REVIEWERS: If both elements RC02 and RC03 are found MET based on IRE data, this universe should not be requested.

Purpose: To determine whether the M+CO complies with regulatory requirements for timeliness and member notice when making fully or partially unfavorable reconsidered determinations on member requests for claims payment. Also, to determine whether the M+CO complies with regulatory requirements for effectuating claims denials reversed by CMS' independent review entity or higher levels of appeal.

Universe: All claims reconsideration determinations made during the review period that were not fully favorable to the member.

Favorable Standard Pre-Service Reconsiderations **Worksheet WS-RP1**

Purpose: To determine if the M+CO complies with regulatory requirements for timeliness and member notice when approving reconsidered member requests for service.

Universe: All pre-service reconsideration determinations made during the review period that resulted in the M+CO reversing its initial denial.

Unfavorable Standard Pre-Service Reconsiderations **Worksheet WS-RP2**

NOTE TO REVIEWERS: If both elements RP02 and RP03 are found MET based on IRE data, this universe should not be requested.

Purpose: To determine if the M+CO complies with regulatory requirements for timeliness and member notice when making fully or partially unfavorable reconsidered determinations on member requests for service. Also, to determine if the M+CO complies with regulatory requirements for effectuating pre-service denials reversed by CMS' Independent Review Entity or higher levels of appeal.

Universe: All standard pre-service reconsideration determinations made during the review period that were not fully favorable to the member.

Requests for Expedited Reconsiderations **Worksheet WS-RP3**

Purpose: To determine if the M+CO complies with regulatory requirements for timeliness and member notice when processing member requests for expedited reconsiderations. Also, to determine if the M+CO complies with regulatory requirements for effectuating pre-service denial reversals by CMS' Independent Review Entity or higher levels of appeal when the request for reconsideration was expedited.

Universe: All requests for expedited pre-service reconsiderations received during the review period, whether or not they were expedited.

Grievances **Worksheet WS-GV1**

Purpose: To determine if the M+CO is responsive to member concerns that do not fall within the purview of the Medicare appeals process. To ensure that the steps and time frames outlined by the M+CO in its Evidence of Coverage (EOC) are being followed and that problem areas are identified, resolved and shared among M+CO departments. Also, to determine if cases categorized by the M+CO and/or the delegated entity as grievances are in fact grievances rather than requests for organization determinations or reconsiderations.

Universe(s): All grievances received during the review period (including those still pending). Please note that the term "grievance" is meant to include all member concerns that do not fall within the purview of the Medicare organization determination or reconsideration processes, regardless of whether the M+CO uses other words to describe them, such as "complaint" or "informal grievance," etc. This includes issues received telephonically as well as in writing.

Part II

Samples to be Reviewed from CMS-Generated Transaction Reply Listings

(The following is included for your information only; the samples will be selected from CMS data - do not submit reply listings to the RO)

NOTE TO REVIEWERS: CMS has no way of differentiating if a delegated entity or an M+CO submitted data into CMS's systems. Therefore, universes for worksheets ER1, ER3, ER4, ER5, ER6, DN1 and DN2 will not be separated into delegated entity and M+CO cases.

Applications and Enrollment **Worksheet WS-ER1**

Purpose: To determine if enrollment applications were processed and beneficiaries were enrolled per CMS standards.

Universe: All action code 61/reply codes 11, 16, 17, 22, and 23 inputs entered by the M+CO, during the review period, and accepted by CMS.

CMS Enrollment Rejections **Worksheet WS-ER3**

Purpose: To determine if the M+CO properly follows up on enrollment rejections and submits appropriate retroactive actions to the Regional Office. In addition, to determine if the M+CO reviews CMS Monthly Transaction Replies/Monthly Activity listings in a timely manner.

Universe: All action code 61/reply codes 31-34, 36, 37, 40, 42, 44, 45, 47, 106, and 110 inputs (enrollments) that were rejected by the CMS system, during the review period, for reasons such as "Beneficiary Not Found," "No Part A," "No Part B, and "ESRD."

EGHP Enrollments **Worksheet WS-ER4**

Purpose: To determine if EGHP (Code 60) applications were processed per CMS standards.

Universe: All action code 60/reply codes 11, 16, 17, 22, and 23 (EGHP-enrollment) where members are enrolled retroactively for inputs entered by the M+CO during the review period.

Institutional Adjustments **Worksheet WS-ER5**

Purpose: To determine if institutional code sets are processed per CMS standards.

Universe: All reply code 75s processed during the review period.

State and County Code Changes **Worksheet WS-ER6**

Purpose: To determine if state and county code changes were processed per CMS standards.

Universe: The SCC reply code 85 - "SCC Change" that were received during the review period.

Voluntary Disenrollments **Worksheet WS-DN1**

Purpose: To determine if voluntary disenrollments were processed per CMS standards.

Universe: Action code 51/reply codes 13, 25, and 26 inputs entered by the M+CO.

Voluntary Disenrollments Through Sources Other Than M+CO **WS-DN2**

Purpose: To determine if voluntary disenrollments were processed per CMS standards.

Universe: All transaction reply codes 14 received, and all action codes 53 & 54 inputs/reply codes 13, 25, and 26 entered by the SSA, RRB, and the CMS Call Center (1-800-MEDICAR(E) during the review period. Cases involving "automatic" disenrollment (loss of Part A, loss of Part B, or death) are excluded.